The Vein Clinic, Inc.

PATIENT MEDICAL HISTORY

Name: _____ **Date:** _____

GENERAL HISTORY

Age: _____

Are You: □ Pregnant? □ Planning a Pregnancy? □ Nursing?

Medications: □ None □ Aspirin □ Plavix □ Coumadin □ NSAIDS □ Birth Control

Allergies: _____

Have you ever had **Any** Reaction to Latex _____ or Tape? _____
Have you ever had **Any** Reaction to a Local Anesthetic? _____
Have you ever had **Any** Reaction to Needle Sticks/Blood Draws, Etc? _____

Do you have a history of migraine headaches? □ Yes □ No

Do you have a heart murmur? □ Yes □ No

Previous Surgeries to Legs? _____

History Of: □ Lung Blood Clot □ Deep Vein Thrombosis □ Bleeding Disorder
□ HIV □ Hepatitis B/C □ Herpes □ None of the Above

VEIN HISTORY ***PLEASE BE SURE TO COMPLETE ALL SECTIONS***

How many years have you had a problem with Varicose and/or Spider Veins? _____

SYMPTOMS: □ None □ Burning □ Itching □ Tingling □ Cramping □ Heaviness
□ Leg Fatigue □ Leg Rash □ Pain/Discomfort □ Ulcer □ Swelling □ Other _____

Do you have a family history of Varicose and/or Spider Veins? □ Yes □ No

Have you ever been treated for Varicose and/or Spider Veins? □ Yes □ No

If Yes, When? _____ By Whom? _____

What Method? □ Stripping □ Ligation □ Laser □ Injections

Do any of these statements apply to you?

□ My legs hurt when I work because I stand most of the day.

□ My legs hurt during the day and pain is worse by the end of the day.

□ My legs get swollen by the end of the day.

□ My legs feel heavy and I cannot be as active.

□ I have to raise my legs because they hurt.